



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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COMMITTEE OF DIETETICS/NUTRITION
EXPERIENCE ASSESSMENT FORM

The following applicant is applying for certification as a dietitian/nutritionist in the State of Delaware. As the supervisor of the experience requirements, your evaluation of the applicant's performance is important in determining if the experience meets the requirements.

APPLICANT NAME (Please print or type):

Last First Middle Initial

INFORMATION ABOUT SUPERVISOR:

Name: _____
Last First Middle Initial

Registered Dietitian: Commission on Dietetic Registration (CDR) # _____

Licensed Dietitian: License # _____ State _____

Certified Dietitian/Nutritionist: Certificate # _____ State _____

Certified Nutritional Specialist: Certificate # _____ State _____

Licensed Physician: License # _____ State _____ (A licensed Physician must submit documentation indicating expertise in Human Nutrition.)

Place of employment when supervising applicant: _____

Date of supervision: _____
Starting Date Ending Date

Position held: _____

Current position: _____

Address: _____

Telephone Number: _____ E-Mail: _____

INFORMATION ABOUT APPLICANT:

Total number of practice hours: _____

Place of Supervision: _____

Applicant's primary duties: _____

Outline of applicant's planned work experience with time allotment specified for each activity:

Assessment of applicant's performance: _____

I hereby certify that the above statements for the work done by the applicant while under my supervision are true.

Signature of Supervisor

Date

Please return completed form to: Committee of Dietetics/Nutrition
861 Silver Lake Blvd., Suite 203
Cannon Building
Dover, DE 19904